CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 2, 1998

H.R. 3523 / S. 2007
Health Care Claims Guidance Act

As introduced

SUMMARY

H.R. 3523/S. 2007, the Health Care Claims Guidance Act, would reduce the scope of cases involving a federally funded health care program that may be enforced under the False Claims Act. The bill would limit action under the False Claims Act to cases in which the alleged damages are a material amount as defined in consultation with the American Institute of Certified Public Accountants (AICPA). It would increase the standard of evidence from "a preponderance of the evidence" to "clear and convincing evidence." And it would prohibit the government from pursuing a case under the act against an entity that is in "substantial" compliance with a model compliance plan issued by the Secretary of Health and Human Services.

CBO estimates that enacting H.R. 3523/S. 2007 would increase federal spending by $0.3 billion in fiscal year 1999 and $2.2 billion over the 1999-2003 period. The legislation would affect direct spending and receipts; therefore, pay-as-you-go procedures would apply.

H.R. 3523/S. 2007 contains no intergovernmental or private-sector mandates as defined by the Unfunded Mandates Reform Act. However, state and local governments may face increased Medicaid costs totaling $60 million in fiscal year 1999 and increasing to $75 million in fiscal year 2003.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 3523/S. 2007 is shown in the following table.

	By Fiscal Year, in Millions of Dollars				
	1999	2000	2001	2002	2003
DIRECT SPENDING					
Medicare and Medicaid					
Change in outlays	300	400	500	500	600
SPENDING SUBJECT TO APPROPRIATION					
Defense Health Program					
Change in outlays	0	2	2	2	2

The discretionary costs of this legislation fall within budget function 050 (defense), and the direct spending costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

BASIS OF THE ESTIMATE

CBO's analysis is based on discussions with and data from the Departments of Justice and Health and Human Services and with health care provider organizations. CBO estimates that mandatory federal spending would increase in two ways as a result of the provisions in H.R. 3523/S. 2007.

First, by limiting the cases that may be pursued under the False Claims Act and increasing the level of evidence necessary to prove a case, the bill would reduce the number of cases prosecuted and the amounts collected in recoveries and fines. Much of the reduction would result from a decline in the number of cases initiated by citizens under the qui tam section of the False Claims Act, which permits citizens who learn of a fraud against the federal government to report it to the Department of Justice and receive a percentage of any recoveries or fines. In most cases these relators are employees of a firm committing fraud and risk losing their jobs by reporting the fraud. Enactment of H.R. 3523/S. 2007 would significantly reduce the number of frauds reported, because qui tam relators would be

financially rewarded only in instances that meet the bill's more restrictive standards for prosecuting and proving a case.

CBO estimates the federal government collects more than $300 million per year in penalties and multiple damages and in recoveries from qui tam suits. The bill would slightly reduce collections in 1999 as the new standards for prosecuting and proving a case would be applied to cases already in the pipeline. The drop in the number of qui tam cases reported would cause the loss of collections to grow to about $100 million a year in 2000 and subsequent years.

Second, federal spending would rise because of an increase in erroneous payments. Under current law, health care providers know that if they file claims inaccurately and if these claims are identified they could be required to pay penalties in addition to the amount of the erroneous claim. To the extent that these penalties are an added deterrent, providers increase their effort to file accurate claims and emphasize compliance programs. Under the bill, providers would be able to file claims inaccurately without penalty on condition that the amount of such claims did not sum to a material amount. According to the AICPA, a material amount can be as much as 5 percent of the total claims paid to the provider in a given year. Providers would be able to avoid penalties even in cases where alleged damages were a material amount if these providers were in substantial compliance with a model compliance plan or if the requirement of clear and convincing evidence could not be met. CBO estimates that limiting the False Claims Act would decrease its deterrent effect and result in an increase in the volume of inaccurate claims. Federal spending on Medicare and Medicaid will be about $330 billion in 1999. CBO estimates that under H.R. 3523/S. 2007 spending for inaccurate claims would rise by about 0.1 percent of total spending for these programs—$0.3 billion in 1999, growing to $0.5 billion in 2003 and $0.9 billion in 2008.

In addition to its effect on mandatory spending, H.R. 3523/S. 2007 would also increase discretionary spending by the Defense Health Program under Title 10. Each year Congress appropriates funds to the Department of Defense (DoD) for the provision of health care coverage to active-duty personnel and military retirees and their dependents. Military beneficiaries can choose to have their care provided in DoD facilities. They also have a choice between fee-for-service care and a managed care plan in the private sector. Under the Tricare program, DoD contracts with private health care organizations to process fee-for-service claims and provide care in managed care networks. The Tricare contractors would experience higher claims costs to the extent that more fraudulent claims are filed and paid on behalf of military beneficiaries under this bill than under current law. Since the cost of the Tricare contracts is based on actual claims paid, an increase in fraudulent claims would ultimately lead to higher expenditures by DoD.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. Because H.R. 3523/S. 2007 would affect Medicare and Medicaid spending and collections, pay-as-you-go procedures would apply. The impact of this provision on federal outlays is shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in outlays	300	400	500	500	600	600	700	800	900	1,000
Change in receipts	Not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Although H.R. 3523/S. 2007 would limit cases where the federal government could pursue fraudulent medical claims, it would neither increase the stringency of conditions of assistance nor decrease funding for the Medicaid program. Consequently, the bill would not contain an intergovernmental mandate as defined by UMRA. State and local governments may, however, incur greater costs from Medicaid claims as a result of this bill.

Because the bill would increase the burden of proof necessary to pursue fraudulent medical claims, health care providers may seek reimbursement for claims that would not have been submitted otherwise. As a result, states and some local governments would face increased Medicaid costs. CBO estimates that the costs to state Medicaid programs as a result of this bill could total $60 million in fiscal year 1999 and increase to $75 million in fiscal year 2003.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

S. 2007 does not include any private-sector mandates as defined in the Unfunded Mandates Reform Act.

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